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ABSTRACT

The high fertility rates among Hispanics and the continuing immigration patterns are making the mental health needs of Hispanics a national concern. The issue of the underutilization of mental health services by Hispanics must become a prominent concern for all Americans. Three main factors in the underutilization of mental health services by Hispanics include: (1) psychotherapist bias; (2) cultural variables; and (3) the underrepresentation of Hispanics in the field of psychology. Evidence has been found of a social class and linguistic bias among psychologists, although the evidence finding ethnic bias against Hispanics has been equivocal. A number of cultural variables have been found to play a part in Hispanic underutilization. These include Hispanic attitudes, levels of acculturation, alternative support networks, and ethnic similarity and credibility. The lack of research on the topic of Hispanic underutilization of mental health services points out the relative lack of interest in the topic. With the growing Hispanic population, a concerted effort is needed to examine the significant issues involved in the delivery of effective, culturally sensitive mental health services to Hispanics. (ABL)

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A CRITICAL REVIEW OF FACTORS IN THE UNDERUTILIZATION OF MENTAL HEALTH SERVICES BY HISPANICS

A Doctoral Research Paper

Presented to

the Faculty of Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements For the Degree

Doctor of Psychology

by

Wayne Charles Boucher

August 1990

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A CRITICAL REVIEW OF FACTORS IN THE UNDERUTILIZATION OF MENTAL HEALTH SERVICES BY HISPANICS

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ABSTRACT

A CRITICAL REVIEW OF FACTORS IN THE UNDERUTILIZATION OF MENTAL HEALTH SERVICES BY HISPANICS

by

Wayne Charles Boucher

In this critical review of the literature, the problem of underutilization of Mental health services by Hispanics was identified and estimates of the current, and rapidly growing, Hispanic population in this country were cited. Three main factors in the underutilization of mental health services by Hispanics were identified through a review of the relevant research. These main factors were: (a) psychotherapist bias, (b) cultural variables, and (c) the underrepresentation of Hispanics in the field of psychology. Evidence was found for social class and linguistic bias among psychologists but the evidence for ethnic bias against Hispanics was equivocal. A number of cultural variables were also found to play a part in Hispanic underutilization. Hispanics were found to be significantly underrepresented among students and faculty in graduate schools of psychology. This underrepresentation is suggested as a cause of Hispanic underutilization of mental health services. Research implications and recommendations are presented.

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DEDICATION

This paper is dedicated to Loraine A. Evans, otherwise known as Nana. Thanks for being there, Nana; I don't think I could have made it through without you. I suppose now I'm dry behind the ears?

A Critical Review of Factors in the Underutilization of Mental Health Services by Hispanics

Introduction

The issue of underutilization of mental health services by Hispanics is one that is close to my own heart, as a person of Latin origins. The high fertility rates among Hispanics and the continuing immigration patterns (from Latin America to the United States) are making the mental health needs of Hispanics a national concern (Bernal & Padilla, 1982; Bernal, Barron, & Leary, 1983). The issue of underutilization of mental health services by Hispanics must become a prominent concern for all Americans, as the Hispanic population continues to grow at the fastest rate of any group in the United States (Rogler, Malgady, Constantino, & Blumenthal, 1987). The increasing Hispanic population is forcing our society to begin to address the needs of this growing segment of the general population. Psychology as a science, and as a profession, has (in general) done very little to the present to address the mental health needs of Hispanics. However, psychology, like society, is being forced by sheer numbers to recognize the problem for this large and growing population.

Hispanics are the second largest minority group in the United States and currently are the largest minority group

in the southwest (Roberts, 1980). In 1962, Mexican Americans (not counting other Latin groups) made up an approximate 9-10% of the total population (Karno & Edgerton, 1969). Since 1970, Hispanics have been exhibiting an annual rate of growth of 6.1%, making them the fastest growing ethnic group in the country (Malgady, Rogler, & Constantino, 1987). According to the 1980 census figures, Hispanics account for approximately 14.6 million people in the United States (Rogler et al., 1987). In 1985, the preliminary census estimates for Hispanics was 16.9 million, a figure that should be considered conservative, as there are many Hispanics in this country who are here illegally and would not be counted in the census data (Rogler et al., 1987).

The underutilization of mental health services by Hispanics should be of acute concern in states where the concentration of Hispanics is thought to be the greatest (e.g., New York, Texas, Florida and California). In California, Hispanics are projected to become the majority ethnic group by the year 2,000 (Here comes the Latino era, 1977).

The major metropolitan areas of this country need to be especially concerned about the mental health needs of Hispanics because, as Bernal & Padilla (1982) pointed out, Hispanic immigrants tend to gravitate to large metropolitan areas. In particular, Los Angeles should be especially concerned, as it has a Mexican population second only to Mexico city (Candon, 1980).

The most recent census data lend support to the findings of Bernal & Padilla (1982), as they have shown that ethnic minorities do not distribute evenly across the nation. Hispanics tend to cluster in certain metropolitan areas. In Los Angeles, as well as in many other metropolitan areas, Hispanics are quickly becoming a majority. Assessing the mental health needs of Hispanics ought to be a high priority for their respective professional communities. However, traditionally the mental health needs of the poor and minority groups have largely been ignored (Lorion & Feldner, 1986). If not ignored, the mental health services provided were often delivered in ways that were not culturally sensitive to Hispanics (Rogler et al., 1987). Many cities are faced with the same problem as Los Angeles, Miami and New York. The mental health systems of these cities, as for large portions of this country, need the ability to accurately assess and deliver services to Hispanics in a culturally sensitive manner.

For many years the literature on underutilization of mental health services by Hispanics interpreted underutilization as an indication of relative absence of psychopathology among Hispanics (Roberts, 1980). However, the traditional underutilization of mental health services by Hispanics does not necessarily imply an absence of psychopathology. Many studies have indicated that there are a number of negative demographic indicators among Hispanics that are usually associated with higher levels of

psychopathology. According to Rogler et al. (1987), Hispanics tend to be younger, poorer, less educated, and live in the inner city. Roberts (1980) echoes the concern of many of the researchers in the area of Hispanic mental health, "that the sociological stressors facing Mexican-Americans and other Hispanics leads to more psychopathology, not less,"(p. 141) as compared to other groups. One of the primary reasons for Roberts' (1980) conclusion was that Mexican-Americans were found to have the lowest education level of any of the major ethnic groups (Anglos or Blacks) in the United States.

Korchin (1980) concurred with Roberts (1980) in suggesting that such sociological stressors as poverty and discrimination would be expected to lead to more psychopathology. The shedding of one's native language and culture, as well as the daily dealings with racism and poverty, provide us with good reasons to believe that Hispanic individuals will experience a higher degree of psychological distress (Roberts, 1980; Bernal & Padilla, 1982). These negative demographic findings suggest a greater rather than lesser need for mental health services (in Spanish as well as English) presented competently in a culturally sensitive setting (Bernal & Padilla, 1982).

The notion that Hispanics may have a greater need for mental health services seems to have some empirical basis, as a number of psychological researchers have obtained significant results (Roberts, 1980). Roberts (1980)

discovered that the prevalence of identifiable psychopathology among Mexican-Americans is at least as high as the overall population and in some respects higher. Mexican-Americans in Roberts' study indicated that they experience less happiness, less positive affect, more difficulties with leisure time, more marital dissatisfaction and more episodes of chronic nervous trouble. There are also indications of a higher prevalence of drug and alcohol abuse among Hispanics, especially among young males (Perez, Padilla, Ramirez, Ramirez, & Rodriguez, 1980).

In light of the previously cited studies the argument presented by some researchers that Latinos underutilize mental health services because they have less of a need, does not seem to hold water. Roberts (1980) made special note of the need for psychological services in Latino communities and suggested some reasons for the failure of traditional approaches to treatment. He pointed out some of the basic values that may underlie psychology's relative insensitivity to the needs of Mexican-Americans. Roberts (1980) concluded that the underutilization of mental health services by Hispanics is primarily a function of barriers to use, rather than less need. Minorities, in general, continue to need more and receive less quality mental health care than do majority group members (Korchin, 1980). This seems to be particularly true for Hispanics.

Psychology as a science and as a profession ought to be leading the way, in terms of understanding the needs and

concerns of Hispanics, as the needs of the Hispanic community are a growing social concern. Yet, despite their growing population in the United States, the Spanish speaking/surnamed population receives the poorest quality and quantity of mental health care of any ethnic group in America (Padilla, Ruiz, & Alverez, 1975). Sue, Allen, and Conoway (1978), concurring to some extent with Padilla et al. (1975), concluded that it is the Native Americans and Mexican-Americans that receive the least and poorest quality mental health care of any minority groups in the country. While it may be true that Native Americans receive the least and poorest quality mental health care, Hispanics make up a much larger proportion of the United States population and are therefore proportionally the most underserved population in this country (Padilla et al., 1975). Hispanics are not only the most underserved because of their high numbers, but also because there are indications of higher levels of psychopathology among them (Roberts, 1980). But what are the factors involved in the gross underutilization of mental health services by Hispanics? This is the question that this review will attempt to answer. The research in this area has been scattered, inconclusive, and frequently contradictory. It is the purpose of this review to identify and clarify the major factors in underutilization of mental health services by Hispanics.

While this review focuses specifically on

underutilization of mental health services by Hispanics, it must be kept in mind that underutilization of mental health services by Hispanics is a specific part of a larger problem, that is, the underutilization of mental health services by all minority groups (Yamamoto & Acosta, 1982; Sue, 1988; Olmedo, 1989). Sue (1977) concluded that the research has substantiated the notion that all minority group clients receive unequal and poor mental health services.

Factors in Underutilization

Institutional and Personal Bias

Some of the major factors in the underutilization of mental health services by Hispanics have to do with institutional and personal biases. These biases are a reflection of not only the personal biases and values within the psychotherapist but may also reflect biases and prejudices promoted within psychology as a profession and as an academic discipline.

The idea of institutional prejudice is not new, but is probably the most difficult factor to quantify, and is likely to be the most subtle yet pervasive factor in underutilization. (The scant number of minority psychologists is in some sense a measure of institutional prejudice, but the issue of minority underrepresentation as a factor in underutilization will be explored in further detail later in this review.) The biases inherent in

psychology as a profession and as a academic discipline can be termed institutional prejudice.

Perhaps institutional prejudice is more elusive because of the denial of prejudice within the discipline of psychology. Perhaps the denial of institutional prejudice is a result of needing to appear in ways that are socially desirable according to the institutions' own stated values. Principle three, sections b and c, of the American Psychological Association's Ethical Principles of Psychologists provides guidelines that preclude any justification for discrimination (or knowledge of discriminatory practice) by any institution with which a psychologist might be affiliated (American Psychological Association, 1981).

It is not socially desirable for psychologists to admit to discrimination or apathy (if not outright exclusion of minorities from participation in almost all aspects of psychology) toward minority group concerns. Institutional barriers may preclude recruitment and retention of minority faculty, thus inhibiting a greater theoretical understanding of minority needs in psychology (Suinn & Witt, 1982). This issue is such an important one that it will be explored in greater detail later in this review. But suffice it for now to state that one of the main reasons institutional prejudice seems to persist is because of the limited number of theorists and researchers with an interest in cross-cultural psychology. Some theorists have proposed that

current theory and techniques are inadequate in the treatment of minorities (Korchin, 1980). Others have proposed that there is a need for modification of psychotherapeutic efforts to fit the needs and expectations of low-income and minority patients (Lorion, 1974).

Part of the resistance to change, the current problem of underutilization, seems to be the common notion among many professional counselors that cross-cultural differences are relatively unimportant. This notion appears to be perpetuated by the institutions that train psychologists. Graduate schools in psychology tend to focus on the universal principles of psychology rather than on cultural differences. It is the presumption of many psychotherapists that counseling techniques and theories are equally valid across different cultures. This type of attitude seems to perpetuate institutional prejudice and inhibits the utilization of mental health services by Hispanics. The problem with assuming that one's theoretical perspective and accompanying technique are equally valid across cultures is that it implies that underrepresentation of minority psychologists is not a problem and that a competent counselor should be able understand and help any minority client. This attitude is in direct contradiction with the findings of The President's Commission on Mental Health (1978), which concluded that non-minority therapists who often treat minority clients, lack the skill and knowledge necessary to work with them.

The institutional barriers that often exclude minorities from actively participating in psychology as an academic discipline also seem to play a major part in the underutilization of mental health services by Hispanics. Poor, working class, or minority persons are typically underserved by psychologists whose treatments are usually geared towards the needs of middle- to upper-class non-minority clients (Acosta, 1979; Sue, 1977). Prejudicial attitudes of mental health professionals are usually manifested in either outright rejection of the person or in providing less intensive, less interested, or unenthusiastic care (Lorion, 1974).

Institutions, however, do not exist in a vacuum; they require people who implement the policies of the institutions. The policies of an institution may be written or unwritten, but policies are implemented or not by people, and people have biases; psychologists are no exception. In fact, in recent years all sciences and professions have been questioned in terms of their worldview, and underlying presuppositions (Kuhn, 1970; Barbour 1974). So, the idea that psychotherapists may have biases is not farfetched by any means, though the myth of value-free psychotherapy and psychotherapists lives on (Rogers, 1961).

A psychologist's world view is made up of his/her basic assumptions and values (Larzelere, 1980) which serve as the rationale and guide for the psychologist's theoretical, empirical, and clinical work (Larzelere, 1979). The

difficulty arises not out of the psychologist having a world view but rather because these basic assumptions are unquestioned and are heavily influenced by the socioeconomic (or SES) background of the psychologist and the stereotypes he may have of people from cultures different than his own. Since psychologists tend to come from middle- and upper-SES backgrounds it is easy to imagine how their world views might clash with that of a lower income person. The detrimental effects of stereotyping have been determined by a number of researchers (Atkinson, Morton, & Sue, 1983).

The biases within the individual psychotherapist have traditionally been understood as his or her countertransference issues. Countertransference reactions most relevant to this review are those dealing with fear and prejudice. If these are manifested in the values and attitudes within the psychotherapist they may interfere with the effective delivery of mental health services to persons of a culture different from his or her own. The individual biases of psychotherapists are manifested in many ways, and have been one of the main foci of the empirical research on minorities in psychology.

The Three Main Factors in Underutilization

There have been many factors hypothesized to be involved in the underutilization of Mental health services by Hispanics. The numerous factors that have been proposed by the prominent researchers in this area to explain the underutilization of mental health services by Hispanics can

be logically grouped into three main factors: (a) psychotherapist bias, (b) cultural variables, and (c) professional underrepresentation.

The first main factor involves psychotherapist bias. Psychotherapist bias has been investigated in terms of its differential impact on the assessment, diagnosis and treatment of Hispanics. For the purpose of this review psychotherapist bias refers to errors in clinical judgment due to values, beliefs or methods (held by an individual or institution) that interfere with the successful delivery of mental health services to minority persons.

The second main factor relates to the impact of the cultural variables involved in the underutilization of mental health services by Hispanics. This area of research involves (a) the client's attitudes toward the psychotherapy process, (b) the perceived similarity, liking, and credibility of the therapist, and (c) the assessment of the client's use of alternative social support systems, such as family, church, and folk healers.

Finally, the third main factor involves the problem of underrepresentation of minority persons in the profession of psychology with particular focus on graduate students and graduate faculty members.

Main Factor I: Psychotherapist Bias

There seem to be three basic categories of research relevant to psychotherapist bias with Hispanics: (a) social

class bias, (b) ethnic or racial bias, and (c) linguistic bias. However, before each of these areas of research is explored some clarification of terms seems necessary. Bias, in the study of clinical judgment as it relates to race or SES, has come to be equated with prejudice. However, for the purpose of this paper, bias more accurately refers to errors in clinical judgment as a function of race or socioeconomic status. The distinction between prejudice and errors in clinical judgment may appear minor but the distinction has serious implications. The word prejudice has come to take on a negative connotation over the years, and for our purpose bias should not be equated with prejudice. Bias, without the negative connotations of prejudice, will be used to describe errors in clinical judgment, where persons of minority or low SES are viewed in a overly positive or negative manner.

Two types of clinical judgment biases appear to exist in the research on minorities and low SES patients. The first type of bias has been termed an "Overpathologizing Bias" (Lopez, 1983). Such bias is characterized by research that finds minority or low socioeconomic (low SES) group members more pathological or in more need of treatment, when the psychopathology for the minority and non-minority groups is in fact equal.

The second type of bias has been termed a "Minimizing Bias" (Lopez, 1983). Minimizing bias was seen in studies where clinicians tended to dismiss overt signs of

psychopathology as culturally normal and appropriate, and therefore did not recommend the patient for appropriate psychiatric or psychological treatment.

Clinical judgment has been the most frequently used dependent variable in the research on social class and ethnic bias. Clinical judgment, in the relevant studies reviewed, usually referred to the clinician's conceptualization of the psychopathology of the person in question, and his or her recommendations and/or disposition of a hypothetical case. In the typical analog study, hypothetical case scenarios were varied according to social class or ethnicity or both. Identical symptoms were presented to clinicians or students who were asked to make judgments about the level of psychopathology and then asked to give their recommendation/disposition of the particular hypothetical case.

Type I Bias: Social Class

Researchers have charged that the traditional treatment strategies with low SES patients have been irrelevant (Riessmen, Cohen, & Pearl, 1964), absurd (Dumont, 1968), victim blaming (Ryan, 1971), designed to maintain the status quo (Rappaport, 1977) or even outright racist (Thomas & Sillins, 1972). Is there a basis for these charges against psychology? How does this relate to Hispanics in terms of differential treatment by the mental health system?

Lorion and Feldner (1986) in one of the most recent reviews of the research on this topic were quite pessimistic

about these questions receiving thorough answers. Recent funding cuts and the repeal of mental health system legislation has significantly decreased funding available for the type of research needed to answer these pressing questions. Cuts in funding appear to be compounded by the fact that mental health professionals are at best ambivalent in their commitment to working with low SES clients (Lorion, & Parron, 1985). The ambivalence of clinicians towards working with low SES clients was evident in a recent research study (Kahn, McWilliams, Balch, Chang, & Ireland, 1976). Middle-class and majority therapists in this study reported negative expectations regarding the likely outcome of their treatment with low-income and minority clients. Further, some of the therapists in training directly expressed a strong preference for working with upper middle class patients in private practice rather than in public settings.

Despite the often expressed preference for providing treatment to middle- and upper-income clients, most psychologists and psychiatrists see great numbers of low-income and minority clients (Mitchell & Atkinson, 1983). A recent nationwide survey attempted to replicate a previous study by Mitchell and Namenek (1970). Mitchell & Atkinson (1983) discovered that most psychologists and psychiatrists do indeed see a great number of low SES clients. Previous studies had shown that psychiatrists and psychologists tend to see clients that are markedly similar to themselves in

terms of SES (Yamamoto, James, & Hattem, 1967; Mitchell & Namenek, 1970). However, in 1970, Mitchell and Namenek relied on self-report data only, and in the 1983 study of Mitchell and Atkinson both self report and actual independent estimates of psychologists' and psychiatrists' case loads were made, with some interesting results.

Mitchell and Atkinson (1983) found a discrepancy between the reported percentages of each SES level in their caseloads and the actual percentages of each SES level client they saw. Additionally they found that psychiatrists were more likely to be upper-class and come from an upper SES background than were psychologists. Psychologists and psychiatrists reported that typically about 17% of their cases were of low SES background when in fact about 44% of their typical caseload was of a low SES background. Thus, there was little evidence found to support the notion that mental health professionals do actually discriminate against low SES individuals in the provision of services. But how can we understand the discrepancy between what type of client mental health professionals report seeing and the kind of clients they actually do see?

The hypothesis offered by Mitchell and Atkinson (1983) is that psychologists and psychiatrists are trying to enhance their own prestige and status by reporting more upper- and middle-class patients than they actually see. An alternative hypothesis might be that the psychiatrist and psychologist are unaware of or are ignoring class

differences. In either case, regardless of the mental health professional's preference, almost half of the psychologists' and psychiatrists' patients in the study were of low SES. It stands to reason that if a mental health professional's preference is for upper- and middle-income clients, then low SES patients he or she sees would be likely to receive differential treatment from that practitioner. If this study is any example, then the gravity of the potential problem is very apparent. What the study implies is that most psychologists and psychiatrists are seeing a great number of clients with whom they would prefer not to work and such less preferred clients are likely to receive less preferential forms of treatment.

There is a number of epidemiological studies that indicate that low SES individuals are very high in service utilization (Hollingshead & Redlich, 1958; Dohrenwend, 1969). This finding may at first seem contradictory to the notion that the poor are underserved by psychologists. However, these studies (Hollingshead & Redlich, 1958; Dohrenwend, 1969) do not refer to traditional outpatient forms of psychotherapy. The poor are seen in greater proportion, in the utilization of long-term custodial care, for chronic disorders. Epidemiologists for many years have reported that the true prevalence of mental disorders (the number of cases in the community) is highest in the most socioeconomically disadvantaged segments of society (Dohrenwend et al., 1980). Dohrenwend et al. (1980),

summarizing the results of previous epidemiological studies, concluded that low socioeconomic status relates to high rates of schizophrenia, personality disorders, unipolar affective disorders, and severe nonspecific psychological distress. The pattern found by Dohrenwend et al. (1980) has been repeatedly observed in the United States as well as internationally. The rates of psychopathology among the poor have also been demonstrated to be the highest in urban settings (Lorion & Feldner, 1986).

The correlational studies reviewed by Abramowitz and Dokecki (1977), confirmed the findings of other researchers, that minority and low SES persons are over-represented in inpatient psychiatric hospitals. However, the meaning of this finding is not interpretable in terms of causation, since the studies are correlational. The over-representation could be due to clinical judgment bias, but this hypothesis is confounded by an alternative explanation. The rival hypothesis is that persons of low SES and minority status face a more psychologically noxious, sociocultural and physical environment which results in more severe forms of psychopathology. In either case the results of the findings of the correlational studies have implications about the moral obligation to further study and effectively treat persons of low SES and minority backgrounds.

From the epidemiological studies reviewed by Abramowitz & Dokecki (1977) and Lorion & Feldner (1986), it would appear that psychologists have a great deal of contact and

involvement with low SES individuals. The Mitchell and Atkinson (1983) study also tended to confirm psychologists' continued contact with low SES individuals. Unfortunately, the contact psychologists have with low SES individuals tends to be in institutional settings with patients who have more chronic and severe types of psychopathology. As uncomfortable as may be for psychologists to admit, it appears that differential treatment of low SES individuals does exist. Low SES individuals receive more custodial care, more medication, and less outpatient psychotherapy. But how can we infer from epidemiological studies a negative class bias against the poor?

Because low SES individuals receive less preferential forms of treatment does not necessarily mean that psychologists have a negative bias in their treatment of them. Because these epidemiological studies are correlational by definition, causation cannot be inferred. Alternative hypotheses have been proposed to explain the findings of higher prevalence of certain mental disorders among the poor. The over-representation of the poor in institutional settings may be linked directly to their poverty. Far too often, if one is poor, it is inferred that it is because of a lack of mental ability or because of higher levels of psychopathology. However, economic disadvantage may in fact be an etiological factor in certain mental disorders. In other words, one's mental status may be a consequence rather than a cause of one's economic

status (Lorion & Feldner, 1986). Psychologists tend to have negative expectations for low-income and minority clients (Schofield & Oakes, 1975; Wright & Hutton, 1977; Turner & Armstrong, 1981). Perhaps psychologists tend to have negative expectations because of the institutional settings and adverse circumstances under which low SES patient are likely to be seen for treatment.

On the other hand, middle-income patients are more likely to receive a wider variety of psychological interventions. In a recent analog study, middle-income patients were recommended more often for psychological treatment of all types than were low SES persons regardless of race (Norman & Martinez, 1978). The findings of Norman and Martinez (1978) are consistent with a previous study by Routh and King (1972). Both studies concluded that there was less tolerance of deviance among middle-income persons than lower-income persons regardless of race. Moreover, psychological interventions of all types were more likely to be recommended for the middle-income patient.

Abramowitz and Dokecki (1977) found substantive evidence for the existence of a negative social class bias among psychologists. Their conclusion has a stronger inferential basis than those drawn from reviewing epidemiological studies, as these authors also reviewed analog studies. Less favorable clinical judgment and expectations were attributed to lower- versus middle-class patients in 9 of the 14 analog studies involving socioeconomic status that

were reviewed by Abramowitz and Dokecki. They concluded that low SES patients are more consistently devalued than minority persons, women, or social nonconformists.

The implications of the negative clinical evaluation of low SES patients are not easily understood. According to Abramowitz and Dokecki (1977), the negative evaluation and expectation of low SES persons by clinicians could be evidence of prejudice on the part of the clinician, or it could be an accurate perception reflecting real group differences. Therefore, the psychologist's low expectations and poorer prognosis of the low SES patient may in fact be warranted, according to Abramowitz & Dokecki (1977). Lorion and Feldner (1986) found evidence that low SES patients receive poor treatment because therapists tend to hold discriminatory and stereotypic views. Therefore, they are unwilling to offer real treatment (e.g., outpatient psychotherapy) to the poor (Lorion, 1974). Such therapists may hold a defeatist, self-fulfilling, prognostic view of the poor and are committed to maintaining existing social inequalities and the status quo (Lorion & Feldner, 1986).

There are very few outcome studies involving psychotherapy with low SES clients. It is not really known if low SES patients are amenable to "real treatment," that is, psychological interventions usually reserved for those with money or good insurance coverage. Lorion & Feldner (1986) do examine the question of what types of treatment are most effective with low-income clients. In light of

Mitchell and Atkinson's (1983) findings, it is important to know what types of treatment have been found to be effective with low SES clients. It would appear inevitable that psychologists, whether they like it or not, will be treating a large number of low SES clients (Mitchell & Atkinson, 1983).

Little systematic research has been conducted that examines the differential applicability of different types of treatment for low SES clients. Lorion & Feldner (1986), found only one systematic evaluation of insight-oriented psychotherapy with low-income patients. In that one study (Lerner, 1972), of the 45 low-income black and white patients, one third dropped out of treatment with no significant racial differences between dropout rates or outcome measures. Of the 30 who completed treatment, 23 exhibited significant gains in psychological functioning.

Dropout rate is an important issue, as it has been demonstrated that low SES patients tend to have a higher dropout rate than middle SES patients. But what are the factors involved in the high dropout rate among low SES patients? Vail (1978) found that a same sex therapist-patient match resulted in a higher dropout rate from insight-oriented psychotherapy for low SES patients. Parental expectations about treatment have also been found to be significantly related to dropout rates for children of low SES (Day & Reznikoff, 1980).

Brief problem-focused treatment has been found to not

only be effective with low SES patients but time limited treatment reduces the dropout rates of low SES patients (Yamamoto & Goin, 1966). Behavioral approaches have also been shown to be effective with low SES patients (Sloane, Staples, Cristol, Yorkston, & Whipple, 1975) and are thought to have more diverse cross-cultural applicability than traditional psychotherapies.

Objective evidence of family-oriented treatment with low SES patients is not readily available. Most of what has been written has been presented in the form of case studies. However, there are some indications that family and marital approaches are effective in treating low SES patients (Love, Kaswan, & Bugental, 1972; Minuchin, Montalvo, Guerney, Rosman, & Shumer, 1967). In one study of marital approaches, low SES and middle SES clients were compared in terms of satisfaction with treatment. Cline, Meija, Coles, Kline, and Cline (1984) found a negative relationship between marital satisfaction and therapist directiveness for middle SES patients, and a positive relationship between marital satisfaction and therapist directiveness for low SES patients.

Group treatment has also been found to be effective in the treatment of low SES Hispanics. Herrera & Sanchez (1980) found behavior group therapy highly effective with monolingual Spanish-speaking women. In fact, the attendance of the Spanish-speaking clients was higher than the English-speaking control group (76% Versus 51%). Comas-Dias (1981)

found similar results with low SES Puerto Rican women, who exhibited a significant reduction in depression as compared to controls. Group treatment with Puerto Rican immigrants is also thought to be effective because of the decreased isolation and increased social support that monolingual Spanish-speaking immigrants often experience in such groups (Hynes & Weblin, 1977).

Type II Bias: Ethnic

Ethnic bias on the part of the psychotherapist is one of the most difficult and delicate issues involved in the underutilization of mental health services by Hispanics. Ethnic biases are nothing new but the research on ethnic biases in psychology has focused mainly on Blacks. There have been but a few relevant studies that have examined the therapist's attitudes and expectations of the Hispanic patient. In the early research, it was hypothesized that prejudicial attitudes of psychotherapists contributed to the high dropout rate and underutilization of mental health services by Hispanics (Acosta, 1980). Many of the early studies were correlational but presumed that over-medicating Hispanics and their over-representation in inpatient psychiatric hospitals was caused by the prejudicial attitudes of the clinicians treating them. The inference of causation cannot be made from correlational studies, so a number of researchers set out to discover if prejudicial attitudes of psychotherapists exist and have influence upon their clinical judgment.

In a comprehensive review of the literature up to 1977, Abramowitz and Dokecki (1977) found that the research on psychotherapists' ethnic and social class bias can be categorized into four groups: (a) patient variable correlational studies, (b) patient and clinician variable correlational studies, (c) patient effect analog studies, and, (d) patient by clinician effect analog studies. The majority of the analog studies on racial effects reviewed by Abramowitz and Dokecki (1977) involved black patients and white therapists. Only two studies included Mexican-Americans. One study found no racial effect influenced the clinician's judgment with regards to Mexican-Americans. The other study found that the number of outpatient visits, at a community oriented facility, varied according to race, with whites receiving the most visits, Mexican-Americans the second most, and blacks the least number of visits.

The conclusion of Abramowitz & Dokecki (1977) was that Caucasian clinicians have not generally exhibited negative expectations based on race. In fact, there has frequently been found a bias in the opposite direction, with positive expectations based upon minority status. This would support Lopez's (1983) notion of a minimizing bias. The majority of the early studies focused on the existence of a negative bias against minority and low SES persons, thus a minimizing bias was not even considered. The research on minorities and low SES persons is closely related, as the two factors seem frequently to occur together. Gender also has some

important implications as the majority of low SES persons in this country tend to be female and from a minority group. Gender is an issue that bears mentioning because of its frequent co-variance with race and SES but it is an issue beyond the scope of the present discussion.

The early researchers in psychotherapists' ethnic bias tended to define bias as exclusively negative. It was assumed that because minority groups were over-represented in inpatient settings, this is evidence of prejudice or bias toward seeing minority individuals as more pathological than they really are. It is not clear from the research that the over-representation of minorities in inpatient psychiatric hospitals is evidence of prejudicial attitudes, nor is it clear that all bias is in the negative direction (Lopez 1983).

Lewis, Shanok, Cohen, Kligfeld, and Frisone (1980) identified a factor that had not previously been considered. There was some indication from the research reviewed by Lewis et al. (1980) that there is a tendency among mental health professionals to dismiss signs of psychosis or organic disorders as normal and culturally appropriate for certain minority groups. Lopez (1983) calls this type a "minimizing bias."

Although the minimizing bias hypothesis had not been considered prior to 1979, there was some evidence for it in the research done prior to that time. For instance, Koscherak & Masling (1972), using an analog paradigm,

unexpectedly discovered that low SES patient protocols were more likely to be rated normal or personality disordered, than were middle-class patients who were more often seen as neurotic or psychotic. Overall, lower-class individuals were more likely to be rated less severely whereas the middle-class protocol emphasized more psychopathology (Koscherak & Masling, 1972). Similar findings can also be noted in studies by Routh and King (1972) and Norman and Martinez (1978). In the Routh and King (1972) analog study middle-class persons, with identical symptoms to lower-class persons, were rated as more likely to need professional psychological help.

Although there appears to be significant evidence of a minimizing bias for social class, it is not clear that a minimizing bias exists for ethnicity. For example, in the Norman and Martinez (1978) study involuntary commitment was recommended significantly more for Mexican-Americans than for Caucasians. This recommendation was made by both Mexican-American and Anglo students but the Anglo-American students' ratings accounted for the majority of the variance. Although shy of statistical significance, Anglo raters also recommended psychotherapy more often for Anglos than for Mexican-Americans. Middle-income patients were also recommended more often for psychological treatment of all types than were low SES persons regardless of race. The findings of Norman and Martinez (1978) are consistent with Routh and King (1972) with regard to there being less

tolerance of deviance among middle-income persons than lower-income persons regardless of race. Thus, there appears to be stronger evidence of social class minimizing bias rather than ethnic minimizing bias in respect to Hispanics.

How do minimizing or overpathologizing biases affect diagnosis and/or treatment of Hispanics? It is clear from previously cited data that Hispanics, along with other minority groups, receive inferior and less preferential forms of treatment (Thomas & Sullen, 1972; Lorion, 1973; Padilla & Ruiz, 1973). But is this differential treatment due to bias? It would appear so. Whether the therapist has an overpathologizing or a minimizing bias, in either case he or she is not evaluating the patient accurately and is thus more prone to errors in judgment.

Errors in judgment would appear to affect less-experienced therapists more than experienced therapists (Wampold, Casas, & Atkinson, 1981). In the Wampold et al. (1981) study, it was found that Anglo-American counselor trainees were more susceptible than minority counselor trainees to the influence of stereotypes, when processing information about minority clients. More experienced therapists do not appear to be as influenced by stereotypes. Bamgbose, Edwards, and Johnson (1980) concluded, in their study of 61 male (21 Black & 40 White) clinical psychologists, that diagnosis was guided by case characteristics and not by social class or ethnic bias. Disposition of the cases was

based upon diagnosis rather than bias. According to Bamgbose et al. (1980) the differential diagnosis and treatment of minorities and the poor is likely to be accurate and appropriate. Social and economic factors were proposed to explain the differential prevalence of more severe disorders amongst the poor and minority groups.

With regard to Hispanic patients, little evidence can be found to indicate that psychotherapists have an overpathologizing bias against Hispanics. In fact, there is evidence to the contrary. Clinicians, especially inexperienced ones, often minimize and dismiss psychopathology as culturally appropriate when seen in Hispanics. However, this issue is neither well studied nor understood and further investigation is necessary (Wampold, Casas, & Atkinson, 1980).

Type III Bias: Linguistic

There are many barriers that seem to prevent access to mental health services for all minorities but there are some barriers that are particularly problematic for Hispanics, Asians and Native Americans. For members of these ethnic groups English is often a second language. Since many of the Hispanics seeking mental health services may have very limited or no English skills, the rarity of Hispanic-American or Spanish-speaking therapists is a tremendous problem in the assessment, diagnosis and treatment of Hispanic patients (Acosta, Yamamoto & Evans, 1982). Assessment and diagnosis of Hispanics is particularly

problematic because of the issues of acculturation and mastery of the English language. The less acculturated the patient is, the less likely he or she is to have a mastery of the English language. Even if the Hispanic patient does speak English adequately, his or her reading skills may be very limited in English. Additionally, when a patient speaks little or no English often any available person, such as a family member, is pressed into service as interpreter. Consequently the variance in assessment of the patient may be as much a function of the interpreter's translation skills as the patient's pathology.

Malgady, Rogler, and Costantino (1987) contended that biculturalism is as important as language in the personality assessment of Hispanics. These authors further echo the concern of previous researchers in the area of personality assessment, that is, there remains no valid testing procedure with Hispanics.

The personality test most studied with Hispanics is the Minnesota Multiphasic Personality Inventory (MMPI). Several Spanish translations of the MMPI are available but most are riddled with translation difficulties. Beyond the language problems, it must be kept in mind that the items of the MMPI were keyed empirically on a largely Anglo-American sample. Thus many of the deviations from the norms are indicative of pathology from the standardized Anglo-American diagnostic groups, and may not necessarily reflect pathological behaviors, feelings or beliefs of persons from different

Hispanic subcultures (Malgady et al., 1987).

In a comprehensive review of the literature on ethnicity and MMPI performance, Green (1987) found little support for any consistent differences between Anglos and Hispanics on the standard validity and clinical scales of the MMPI. There appear to be fewer Hispanic-White differences on the MMPI than Black-White differences. Green (1987) indicated that Hispanics do tend to score higher on the L scale and lower on scale 5, but the finding was not consistent across studies. It must be kept in mind that there remains a paucity of research comparing MMPI scores of Hispanics with other ethnic groups. For example, Green (1987) cited only 11 studies conducted since 1970. Another thing to be kept in mind is that these studies used English versions of the MMPI, which implies a certain mastery of the English language, and therefore may represent a more acculturated Hispanic group. A more acculturated Hispanic group would be expected to score in a manner similar to Anglos because of the acculturation that would have already occurred.

If the MMPI is the most researched instrument in the assessment of Hispanics, then projective personality tests are the least researched. The problem with projective personality tests is that there appears to be no projective that can be considered truly culture-free (Padilla & Ruiz, 1975). There is also an inferential problem with attributing psychopathology to the patient's response, as there is a lack of relevant normative data.

The one projective measure that has an objective scoring system, the Rorschach (Exner Comprehensive System), is normed on an American sample. Thus, interpretation of the responses to the inkblots is questionably valid at best. Indeed, preliminary findings of Rorschachs administered to children in Spain, Mexico, and Panama revealed some differences from Anglo children of the same ages (Exner, 1982).

Exner (1982) has also found some differences on the Rorschach between Anglo-American adults and Spanish-speaking adults. In a recent study using a sample of 208 adult non-patients from Spain, significant differences from the American norming sample were found (Exner, 1982).

Formal psychological assessment of Hispanics is an ongoing problem. There has been much criticism leveled against psychology as a field with regards to assessment of linguistic minorities. Olmedo (1981) cited 1980 census data which indicated that approximately 8.5% of the American population is from linguistic minority groups with Hispanics by far the largest linguistic minority group in the country. Olmedo (1981) stated that traditionally intelligence testing of Hispanic children has been conducted in English and has not taken into account their Spanish language abilities. As a result, findings of several studies demonstrating that monolingual, English-speaking children perform better than bilingual children on standardized IQ tests are of questionable validity. These studies cannot be taken at

face value as they do not adequately control for such variables as SES and degree of bilingual skills (Padilla & Ruiz, 1975).

Some efforts have been made to translate formal psychometric testing instruments into Spanish. However, these translated instruments are riddled with problems in the translations, norms and application. Some instruments are translated into formal Spanish while others are translated into more dialectic Spanish. It must be remembered that Hispanics are far from homogenous in many aspects. Norming is also a particular problem as many of these instruments have been normed on specific Hispanic groups (i.e., Puerto Rican, Mexican-American, Cuban) and cross-application may be inappropriate.

The importance of making an accurate assessment of a Hispanic patient cannot be overemphasized. It is increasingly apparent that the first step in assessing the Hispanic patient is the evaluation of his or her language skills and acculturation. Assessing the client's language dominance and preference is seen as the critical first step in accurately assessing, diagnosing, and treating the Hispanic patient (Malgady et al., 1987).

Beyond accurate assessment and diagnosis, language is also the primary prerequisite for any type of effective psychotherapy. Psychotherapy involves communication and dealing with emotions, and people of all ethnic and SES backgrounds label emotions with language. While bilingual

persons may be able to label their emotions in English, their emotional experiences are likely to be coded in their primary language. Childhood experiences are especially likely to be encoded in the person's primary language. Acosta, Yamamoto & Evans (1982) emphasized this as a factor to be considered in effective psychotherapy with low-income and minority clients. Acosta et al. (1982) also emphasized the difficulty in expressing the nuances of feelings in other than one's native language. Thus, being able to use the primary language of the patient would be very helpful when dealing with a monolingual Spanish-speaking client and potentially useful for dealing with the bilingual client.

The language factor cannot be overemphasized as understanding the client's language is a prerequisite for accurate evaluation and is an essential aspect of effective psychotherapy. Short of being able to speak Spanish, the therapist may be able to utilize a bilingual translator to help the Hispanic client. Some researchers have documented clinical successes using trained bilingual translators with a monolingual English-speaking therapist (Acosta, 1979). In one study of the use of bilingual translators, the clients and the therapists were asked to evaluate the experience of using a translator. Interestingly, Kline, Acosta, Austin, and Johnson (1980) found that the patients rated the experience of using a translator as positive, whereas the therapists rated the experience as negative for the patient.

Summary of Main Factor I

Bias was defined as errors in clinical judgment as a function of race or socioeconomic status. Two types of clinical judgment biases appear to exist in the research on minorities and Low SES patients. The first type has been termed "overpathologizing bias," the second type has been termed "minimizing bias" (Lopez, 1983).

There are three areas of study, in which bias was identified as a factor effecting clinical judgment. The three significant areas have been identified as: (a) social class bias, (b) ethnic bias, and (c) linguistic bias. Evidence was found in this review for social class and linguistic bias among psychologists, though evidence for racial or ethnic bias against Hispanics was equivocal. There appears to be strong support for an overpathologizing, social class bias. Less favorable clinical judgment and expectations were attributed to lower- versus middle-class patients in the majority of studies reviewed. In agreement with Abramowitz & Dokecki (1977), low SES patients appeared to be more consistently devalued than minority persons, women, or social nonconformists.

Some of the studies reviewed also gave an indication that there exists a minimizing bias with regards to social class. From several of the studies reviewed, it was concluded that there was less tolerance of deviance among middle-income persons than lower-income persons regardless of race. Although it may seem contradictory at first, the discovery

of a minimizing bias is not inconsistent with the finding of an overpathologizing bias. Whether low-income patients are seen as more pathological (thus are sent to an institution or are heavily medicated) or free of pathology (thus receive no psychological intervention) the result is the same. They receive less preferential treatment than middle- or upper-income patients.

With regards to racial or ethnic bias, little evidence of an overpathologizing bias was found to exist for Hispanics. The few studies that included Mexican-Americans have found little or no racial effects influencing the clinician's judgment of Hispanics, but there were some studies which indicated that Hispanics had a higher dropout rate from outpatient psychotherapy. From the literature reviewed in this study there is concurrence with the conclusion of Abramowitz & Dokecki (1977) that Caucasian clinicians have not generally exhibited negative expectations towards Hispanics based on race. In fact, there is evidence to the contrary. Clinicians (especially those who are inexperienced) often minimize and dismiss psychopathology as culturally appropriate when seen in Hispanics.

From the literature reviewed there appeared strong evidence of linguistic bias against Hispanics in terms of assessment, diagnosis and treatment. The rarity of Hispanic-American, or Spanish-speaking therapists makes accurate assessment, diagnosis and treatment of Hispanic patients nearly impossible.

The first step in assessment and diagnosis of the Hispanic patient is the evaluation of his or her language skills and acculturation. The accurate assessment and diagnosis of Hispanic patients is particularly problematic because of the lack of good psychometric instruments to measure ability or personality. But beyond accurate assessment and diagnosis, language is also the primary prerequisite for any type of psychotherapy. The language factor cannot be overemphasized; understanding the client's language is essential. The language barrier may be the single most important factor in the underutilization of mental health service by Hispanics. Without accurate assessment and diagnosis, and without culturally sensitive psychotherapists, it is unlikely that the Hispanic patient will feel understood and utilize mental health services.

Main Factor II: Cultural Variables

Closely related to language is culture. Language is the vehicle by which culture is transmitted but the ties between language and culture are beyond the scope of this paper. In this study four cultural variables were found to have an impact on Hispanic underutilization of mental health services. They are: (a) Hispanic attitudes toward psychology, (b) acculturation, (c) alternative support, and (d) therapist similarity and credibility.

Hispanic Attitudes Towards Psychology

A hypothesis that has been proposed to explain the underutilization of mental health services is that Hispanics have a negative attitude towards psychological intervention. However, this hypothesis has not been generally supported in attitude studies with Hispanics. In fact, the evidence points in just the opposite direction. Hispanics have generally been found to have a highly positive attitude towards counseling and a high regard for professional counselors (Acosta & Sheehan, 1976). Acosta & Sheehan found that both Mexican-American and Anglo-American junior college students had similar expectations regarding psychological treatment. Both groups thought that the therapist would most likely ask questions and help them figure out an answer to their problems or listen and allow them to figure out their problems on their own.

In a similar study by Acosta (1979) Mexican-American and Anglo-American outpatients were found to have very similar expectations regarding the therapist's behavior and the length of treatment. Both groups expected that the therapist would engage in active dialogue with the patient and that therapy would take a long time. The two groups, however, did differ slightly in their definitions of "emotionally disturbed" and "mental illness" but both groups defined "mental illness" as more pathological than "emotionally disturbed." The findings of this study have some serious implications, since they demonstrate that

Mexican-Americans (at least those in East Los Angeles) have a fairly sophisticated and positive attitude toward psychotherapy.

The Acosta (1979) study in some sense contradicted the hypothesis that differences in the expectations of low-income Hispanic patients accounts for underutilization of mental health services and high dropout rates (Lorion,1973). Despite a generally positive regard for psychology and counseling, and similar pretherapy expectations, Hispanics still underutilize mental health services (Acosta, Yamamoto, & Evans, 1982).

Why is it that Hispanics continue to underutilize mental health services, despite a generally positive attitude towards psychology and fairly sophisticated pretherapy expectations? This is the question that a number of researchers have attempted to answer. What are the factors involved in the continued underutilization of mental health services and the often overlooked companion problem of premature termination of psychotherapy by Hispanics and other minorities?

Sue (1977) found that premature termination was significantly higher for Hispanics, Asians, and Blacks as opposed to Anglo-Americans of the same SES level. Other researchers have discovered a similar pattern of premature termination among minority group members (Baekeland & Lundwall, 1975; Lorion, 1974). This differential dropout rate is consistent even when education and income levels are

controlled for through matching (Acosta, 1980).

Acosta (1980) examined the self-described reasons for premature termination of psychotherapy by Mexican, Anglo and Black Americans. He found that the most dominant factors for premature termination among these groups were negative attitudes towards the therapist and the perception that therapy provided no benefit. It must be noted that 82% of the therapists in this study were Anglo-Americans; the majority were also middle-class. In descending order, the seven main reasons for premature termination given by the clients in Acosta's (1980) study were: (a) negative attitude towards the therapist, (b) therapy of no benefit, (c) environmental constraints, (d) self-perceived improvement, (e) appointment mix-up, (f) situational impediments, and (g) perceived therapist's termination.

Interestingly, Mexican-Americans differed in Acosta's study from Anglo and Black Americans in their reasons for premature terminations. The Black and Anglo patients rated a negative attitude toward the psychotherapist more frequently than Hispanics as the reason for terminating. No one reason for termination was given by the Mexican-Americans in Acosta's (1980) study. The Mexican-Americans rated three reasons for premature termination with equal frequency: (a) therapy of no benefit, (b) environmental constraints, and (c) self-perceived improvement. Thus, Mexican-Americans were the least negative in their reasons for terminating therapy. In the same study Mexican-

Americans were also more likely than Blacks or Anglos to recommend psychotherapy to others and to see psychotherapy as helpful in the future if they were again to have emotional difficulties (Acosta, 1980).

The findings of Acosta (1980) are consistent with previous studies which indicated that Mexican-Americans have a significantly more favorable attitude towards the potential usefulness of psychotherapy than Anglo-Americans (Acosta & Sheehan, 1976). The findings of Acosta (1980) also support the impressions from other studies, that the behaviors, treatment approaches and attitudes of the therapist may be the most critical variables in explaining the high rates of premature termination among low-income and minority clients (Baekeland & Lundwall, 1975; Lorion, 1974; Sue, 1977).

Acosta et al. (1982) proposed five reasons why Hispanics underutilize mental health services and have a high dropout rate: (a) language difficulties, as many Hispanic clients have difficulties with the English language, (b) social class differences from the therapist, (c) insufficient numbers of mental health facilities in their areas, or lack of knowledge of the facilities available to them in their immediate areas, (d) the tendency of Hispanics to rely excessively on the family physician for help with emotional or psychological problems, and (e) the tendency of Hispanics to wait for very long periods of time before seeking psychological help (thus, a stronger likelihood of

spontaneous remission of acute psychological crisis by the time they get to see a practitioner).

The tendency to wait until their situation has deteriorated seriously before seeking psychological help may explain why Hispanics tend to be over-medicated by the general practitioner (Acosta, 1979). The finding that Hispanics tend to be over-medicated is fascinating, in light of their tendency to attribute relatively less importance to pharmacological intervention than do Anglo patients (Kline, Acosta, Austin, & Johnson, 1980).

Levels of Acculturation

Beyond language difference there are levels of acculturation among the diverse Hispanic groups. Many Hispanics, particularly Mexican-Americans, trace many generations of their families within the states in which they are currently living. This is especially true in Texas and California where many Mexican-Americans look upon the Anglo population as the newcomers. It is important to recognize that only a century and a half ago areas that had been part of Mexico (e.g., California, Arizona, New Mexico, and Texas) were annexed by the United States. This fact seems to be more saliently remembered in Mexico than in the United States (Candon, 1980).

Because some Hispanic families have lived in the United States for generations while others are among first generation immigrants, it is important to recognize their diversity as well as their levels of acculturation.

Acculturation refers to the complex process whereby the behaviors and attitudes of the immigrant change toward the dominant group, as a result of exposure to a cultural system that is significantly different from his or her own (Rogler et al., 1987). Acculturation occurs at different rates depending upon the location and isolation of the individual from his native culture. The level of acculturation is an important consideration in choosing the treatment modality best suited to the patient.

The level of acculturation is also thought to be an important factor in self-disclosure, above and beyond the obvious problem of language differences. It has been postulated that emotional expression is freer and more spontaneous in an individual's own native tongue and the use of a second language fosters intellectual defenses and control (Pitta, Marcos, & Alpert, 1978). Mastery of a second language is in some sense a function of the level of acculturation. In some families, parents may insist that the children speak English only in the home, while others may insist on Spanish only. Thus, level of acculturation and mastery of the English language are important factors to consider in the underutilization of mental health services.

Self-disclosure by Hispanics to mental health professionals has been examined by several researchers. Acosta & Sheehan (1978) hypothesized that the self-disclosure style of Mexican-Americans may play a role in their underutilization of mental health services. Results

indicated that although Mexican-Americans and Anglo-Americans in general had a positive tendency to self-disclose, Mexican-Americans tended to self-disclose less overall than did Anglo-Americans. These differences held even when socioeconomic status was controlled for (Acosta & Sheehan, 1978). Interestingly, the Mexican-American junior college students in this study disclosed less to a Mexican-American therapist than did Anglos to an Anglo-American therapist. Although Anglo-Americans were higher on self-disclosure, this should not be taken to imply that Mexican-Americans are low in self-disclosure and therefore poor candidates for psychotherapy. On the contrary, as Acosta and Sheehan noted, the finding that Mexican-Americans in this study were quite self-disclosing is one of the major contributions of the study, a finding that stands in stark contrast to Mexican-Americans' relatively limited utilization of mental health services.

Beyond ethnic differences in self-disclosure, are there self-disclosure differences among Hispanics that vary according to the level of acculturation? This was the question posed by Franco, Malloy, and Gonzalez (1984), which they answered with an equivocal "yes." Franco et al. (1984) discovered that Hispanic and Anglo females self-disclosed more than did the males of the same ethnic groups. No overall ethnic group differences were found on measures of self-disclosure but there was evidence that self-disclosure is related to the degree of subjects' acculturation. On

reported self-disclosures to another about "money" and "body" the level of acculturation correlated significantly with the amount of self-disclosure. The more acculturated the person, the more self-disclosure was reported about these areas.

A few attempts have been made to understand the role of culture and acculturation in the assessment, diagnosis and treatment of Hispanics. Language is of obvious influence in assessment, diagnosis, and treatment of Hispanics but culture and acculturation are of much more subtle influence. While many studies have discussed how assessment and diagnostic methods fail to address the influences of culture, attempts to evaluate how Hispanic culture is considered in assessment, diagnosis and treatment of Hispanics has been examined basically by only one researcher.

Lopez & Hernandez (1986) surveyed 118 licensed social workers, psychologists, and psychiatrists from California in an attempt to discover how culture is considered in the evaluation of psychopathology. From this survey, Lopez & Hernandez discovered that 83% of the practitioners reported taking culture into consideration for most or all of their culturally different patients. The practitioners were also asked to provide a case summary demonstrating how they took culture into consideration in their evaluation of a specific case.

A qualitative analysis of the 96 case summaries provided

by the clinicians revealed that culture is generally taken into account throughout the treatment process. Of the 96 case summaries, 35 were of Hispanics (Lopez & Hernandez, 1986). A disturbing finding of this survey was that in cases where changes in diagnosis or treatment were made as a result of cultural considerations the great majority of changes were in the direction of judging presenting problems to be less severe. The difficulty here, according to Lopez & Hernandez (1986), is that clinicians may be dismissing real psychopathology as merely a cultural artifact. The author argued that it is important to take culture into account but equally important to do it well, because a minimizing bias may be just as damaging as an overpathologizing bias.

In a follow-up study, Lopez and Hernandez (1987) looked more specifically at how culture is considered in the treatment of Hispanic patients. To do this they examined the 35 Hispanic case histories from their previous survey in an attempt to discern how the clinicians decided what was cultural and what was psychopathological. Of the 35 Hispanic cases only three clinicians provided a rationale for how they knew the problem was culturally based. A problem that Lopez and Hernandez (1987) noted is that clinicians are utilizing their own notions of how culture should be considered. Without empirically based guidelines, how are clinicians able to distinguish what is cultural from what is pathological? Also, are clinicians appropriately

considering culture or are they applying stereotyped notions which may not apply to their patients at all? These are important questions which at this point in time remain unanswered. The heterogeneity of Hispanic peoples begs for an answer.

Alternative Support Networks

Another hypothesis proposed to explain the underutilization of mental health services by Hispanics is their reliance upon alternative networks of support. As previously cited (Keefe et al., 1978), Hispanics tend to go to family, then to friends, and finally to a priest, when experiencing emotional difficulty. Another alternative resource worthy of mention in dealing with emotional difficulties is the reliance on folk healers or Curanderos. Reliance on family for help with emotional difficulties is a common culturally sanctioned practice among Hispanics (Acosta, Yamamoto, & Evans, 1982). It is important to understand that the typical Hispanic family is different in its structure from the typical Anglo-American family. The Anglo family is more generally nuclear-focused, while the Hispanic family typically has strong ties to extended family members (Keefe, Padilla, & Carlos, 1978). Such difference in the Hispanic family structure nay account for a greater reliance upon family in dealing with emotional problems. This may be attributable to the fact that in extended families there are more relationships from which to choose, and wider variations in age and perceived wisdom of

different family members. Therefore, particular members of an extended family may act as a counselors to other family members.

Since most Hispanics are either nominal or practicing Catholics, it is natural that Hispanics would tend to rely on the church structure and a priest in dealing with emotional difficulties (Keefe et al., 1978). The role of the priest as the confessor is an ancient one, and it makes sense that this reliance often translates into a reliance upon a priest for help with emotional problems. Some of the most active Catholic churches in the United States are in areas where there is a high density of Hispanics. East Los Angeles, for example, has the highest concentration of Mexican-Americans in the United States (Acosta, 1979).

Because of the overwhelming need for mental health care in the greater Los Angeles area, the Catholic church has its own network of paid and volunteer staff that provides a variety of social services. It seems natural that many Hispanics would go to people who speak their native language and whom they know and trust, when they are having emotional difficulties. The alternative support network that the church provides may play an important part in relieving the psychological pain of many Hispanics and may be a major factor in the underutilization of mental health services. Fears of deportation may also play an important role in Hispanics seeking help from the church rather than from a public institution, as the church provides sanctuary to

those who are in the United States illegally. On the other hand, the Hispanic patient may have already had negative experiences with public institutions. Perhaps, psychologists should examine more closely how the Catholic church is attempting to meet the emotional needs of Hispanics and should adopt some of its methods in outreach and service provision.

Some researchers have hypothesized that Hispanics' reliance upon Curanderos as an alternative treatment approach for psychological problems may be a possible reason for underutilization of mental health services (Creson, McKinley, & Evans, 1969). Although, there is some evidence of Hispanics seeking help for psychological or spiritual problems from these folk healers, their reliance upon them is not likely to significantly impact the use of mental health services. Keefe, Padilla, and Carlos (1978) found that the Hispanic's reliance upon these practitioners was minimal. Furthermore, subjects in their study identified physicians as the persons to whom they would most likely go when facing emotional disorders with physical manifestations. For other emotional problems, subjects said that they would turn to family, friends, or a priest, in that order. Hispanics, similar to Anglo-Americans, tend to exhaust all other possibilities before seeking assistance from mental health professionals.

Although not extensively utilized, Curanderismo is thought to be more common in rural Mexico and the central

barrios of urban Mexico (Acosta, Yamamoto, & Evans, 1982). Curanderismo is also thought to be more common in Texas than in California (Kiev, 1968; Edgerton, Karno, & Fernandez, 1970). A number of studies have compared Curanderismo to the practice of modern psychotherapy (Edgerton et al., 1970). Although modern medical services are available and used by Mexican-Americans for physical illnesses, a significant number of Mexican-Americans continue to utilize Curanderismo as an alternative to modern psychiatry (Kiev, 1968).

The reliance upon Curanderismo is also likely to be a function of the person's level of acculturation, education, and language ability. In short, persons who rely on such a practitioner are likely to be those whom psychologists have typically been least able to reach, namely the poor, the uneducated, the less verbal, and the low SES and minority group members. If psychologist/psychotherapists are to reach the Hispanic population, cultural sensitivity and Spanish language ability are essential.

Therapist Similarity and Credibility

The role ethnic similarity plays in the therapy process is an unsettled controversy. Some have proposed that therapists who are ethnically similar to their clients are better able to understand, intervene and provide a role model (Acosta, 1976). Others argue that a culturally sensitive counselor should be able to transcend cultural differences (Abramowitz & Dokecki, 1977). There are good

arguments for either position.

Drawing from the social psychological theories of social influence and social learning, perceived similarity and attraction are important elements of change and of influence in behavior (Bandura, 1977). Social learning theory (Bandura, 1977) argues for the importance of perceived similarity as a factor in the perceived attractiveness of a model. Also, the more attractive the model is perceived to be the more likely the behavior of the model is to be imitated and learning to take place. Thus, a client and therapist ethnic match may be hypothesized as a possible important factor in influencing and affecting change in the Hispanic client.

Atkinson (1983) reviewed the research on ethnic similarity for four minority groups (American Indians, Asian Americans, Blacks, and Hispanics). He discovered only two studies of Hispanics' preferences with regard to the therapist's race. No preference effect for race was found in either of the two studies (Backner, 1970; Gordon & Grantham 1979). The only consistent finding of racial preference, in Atkinson's (1983) review, was for Blacks. Black patients preferred a Black counselor in 8 of the 12 studies reviewed, spanning more than a decade of research. Atkinson concluded that the preference for a counselor of the same race was a function of the level of acculturation of the patient; that is, the less acculturated the patient, the more same-race preference. But whether ethnic matching

has any bearing on psychotherapy outcome variables is still a matter of conjecture, as the question remains unstudied (Atkinson, 1983).

Acosta & Shehan (1976) is one of the few studies that have attempted to study directly ethnic preference of Hispanics with regard to their therapist. In this study, subjects (Anglo- & Mexican-American college students) were presented matched audiotapes of a "therapist" with either a standard American or Spanish accent. The two tapes were identified to the subjects as either an Anglo-American professional or non-professional and a Mexican-American professional or non-professional counselor. The results of this study indicated that Mexican-American college students preferred the Mexican-American non-professional most, the Anglo professional next, Anglo non-professional third, and finally the Mexican-American professional least. Despite these results, on other measures the Mexican-American students demonstrated a very positive attitude towards psychology, and saw professional psychology as potentially beneficial for anyone having emotional difficulties. The results of this study are puzzling and it appears that Acosta & Shehan's (1976) findings are consistent with those of Atkinson (1983) in that there emerged no strong pattern of ethnic preference for Hispanics.

Perhaps more important than ethnic similarity in meeting the mental health needs of Hispanics is the issue of therapist credibility. Atkinson (1983) identified three

dependent measures of therapist credibility: (a) perceived counselor expertise, (b) perceived counselor trustworthiness, and (c) perceived counselor attractiveness. In his review of the literature, Atkinson (1983) discovered only three studies that employed Hispanic subjects. In none of the three studies did race or ethnicity produce a significant main effect, nor did counselor expertise (Atkinson, 1983). In only one study was attitude similarity found to have a significant main effect on measures of counselor credibility (Acosta & Shehan, 1976). The only other study using Hispanic subjects (Acosta & Shehan, 1978) measured self-disclosure to Anglo male and female administrators and Hispanic male and female administrators. In this study there were no main effects for ethnicity, but Hispanic females were found to disclose significantly more to female administrators regardless of ethnicity and Hispanic males were found to disclose the most to Hispanic female administrators (Atkinson, 1983).

Summary of Main Factor II

A number of cultural variables was also found to play a part in Hispanic underutilization. A hypothesis that has been proposed to explain the underutilization of mental health services is that Hispanics have a negative attitude toward psychological intervention. From the literature reviewed above this has not been found to be true. The attitude studies reviewed found Hispanics to have a highly positive attitude toward counseling and a high regard for

professional counselors. Another variable that appears to be involved in Hispanic underutilization is acculturation. Acculturation was found to occur at different rates depending upon the location and isolation of the individual from his native culture. The level of acculturation is an important consideration in choosing the treatment modality best suited for the patient.

From this review, a significant cultural variable was discovered that may account for much of the underutilization of mental health services by Hispanics. This variable is Hispanics' traditional reliance upon alternative support networks. Hispanics were found to go to family, then friends, and finally to a priest, when having emotional difficulty. The alterative support network that the church provides may play an important part in relieving the psychological pain of many Hispanics and may be a major factor in the underutilization of mental health services. Reliance upon Curanderos has been hypothesized as another alternative support network, however, Hispanics' reliance upon them is not likely to significantly impact the use of mental health services.

From this current review the role ethnic similarity plays in the therapy process for Hispanics remains an unsettled controversy. No preference effects for race were found among Hispanics in the literature reviewed; the only consistent finding from the research on racial preference was for Blacks (Black patients preferring a Black

therapist). More important than similarity in meeting the mental health needs of Hispanics is the issue of therapist credibility. Atkinson (1983) identified three dependent measures of therapist credibility: (a) perceived counselor expertise, (b) perceived counselor trustworthiness, and (c) perceived counselor attractiveness. From the literature reviewed in this study there is concurrence with Atkinson (1983). However, another measure of therapist credibility should be added, that is, mastery of the native language of the patient. In dealing with less acculturated Hispanics a degree of mastery of the Spanish language would seem essential in the patient's perception of therapist credibility.

Main Factor III:
Hispanic Underrepresentation in Psychology

There are relatively few minority students in psychology but there have been several studies that have attempted to estimate the representation of minorities in the field. The measure of representation is derived from two sources: (a) the number of admissions to graduate schools of psychology, and (b) the number of minority faculty in departments of psychology. The magnitude of the problem of minority underrepresentation is best understood by keeping in mind that minorities represent somewhere between 20-25% of the nation's total population (Olmedo, 1989). The following portion of this review will explore facets of

underrepresentation dealing with graduate school departments of psychology, minority students, and minority faculty with a resulting note on the process of underutilization.

The Minority Graduate Student

Although the following discussion applies to most ethnic minority groups, its focus is on Black and Hispanic minority students and faculty specifically as these account for the two largest ethnic minority groups. Another reason for focusing on Blacks and Hispanics is that they are the best researched of the minority groups. By giving the estimate of Blacks in psychology, the intent is to provide some basis for comparisons with Hispanics in terms of their respective proportions in the total population.

In April 1969, at a conference on the recruitment of Black and other minority students, the American Psychological Association (APA) began to show concern about the severe underrepresentation of minorities in graduate schools/departments of psychology both in terms of faculty positions as well as in the number of students (Albee, 1969). The conference explored the issue and began to devise intervention strategies to remedy the problem. Included in these strategies were: (a) more elastic admission requirements for minority graduate applicants, (b) improvement of educational opportunities at the elementary and secondary school level, (c) increased recruitment of minority students and faculty, (d) making financial assistance more available to minority candidates, and (e)

providing programs to bridge any educational gaps that a minority student might have (Albee, 1969).

The strategies suggested by the conference were consistent with, and in some ways anticipated the challenge from, the Black Student's Psychological Association (BSPA), (Simpkins & Rafael, 1970). The BSPA challenged the APA with five areas of concern: (a) the recruitment of black students, (b) the recruitment of black faculty members, (c) financial aid information and its availability to black students, (d) provision of programs with community experience for black students, and (e) research on the needs of the black community and adequate training for all psychologists to assist them in meeting the special needs of the black community. The moral and financial commitment of the APA following the challenge by the BSPA has had a lasting impact but these affirmative action strategies have fallen far short of their lofty goals. The underrepresentation of minorities is still a major problem for the field of psychology.

In 1970 it was estimated that Blacks accounted for only 2.5% of graduate students in psychology and Hispanics accounted for only 0.72% (Boxley & Wagner, 1971). In a follow up study of clinical psychology students, Padilla, Boxley, and Wagner (1973) found that by 1972 Blacks still accounted for only 5.04% of the graduate students and Hispanics only 1.52%. The authors examined and reviewed the trends and effect of affirmative action policies on the

number of minority students and faculty in psychology. Trends discussed in the article point to relative stability of the low numbers of minorities in psychology at all levels.

In fact, Padilla et al. (1973) concluded that no significant change in the number of minority faculty had taken place, though the number of Black graduate students was increasing. A slight improvement was noted in terms of numbers of Hispanic graduate students. The study showed that the problem of underrepresentation is particularly acute for Hispanics as they were found to be proportionally the most underrepresented of all minority groups. Although the number of minority admissions had increased, intense recruitment efforts were still needed.

The underrepresentation of minorities in psychology has seemed to remediate very slowly. Most researchers had noted only small improvements in the overall numbers. However, a leveling off trend soon became apparent (Suber, 1977). Kennedy and Wagner (1979) studied the numbers of minorities in clinical graduate programs as well as in other areas of psychology. Their study, based on survey data, showed that in 1977 Blacks accounted for 8.45% and Hispanics 3.56% of clinical psychology graduate students. Although these studies showed some gradual increases in overall enrollment the evidence indicated that minority enrollment had leveled off (Suber, 1977).

Later studies have tended to substantiate Suber's (1977)

contention of the leveling off of graduate admissions of minority students. Grant and Eiden (1982) found that Blacks accounted for 4.17% of Ph.D. degrees granted in psychology whereas Hispanics accounted for only 2.4%. Although these findings are not comparable with admission statistics they do seem to indicate some stability in low numbers of minority graduate students. It must be kept in mind, however, that the number of minority students enrolled at any one time is not indicative of how many will graduate with the doctorate in psychology.

Another indication of the relatively low and stable numbers of minorities in psychology is their membership in the American Psychological Association (APA). Russo, Olmedo, Stapp, and Fulcher (1981) found that only 3.1% of the APA membership was comprised of minorities, including minority members with a master's level of education. In this same study Russo et al. (1981) found that minorities accounted for only 8.0% of Ph.D. degrees in psychology. They did not break down the percentage figure for each type of minority but the statistics would probably be consistent with the findings of Grant and Eiden (1982).

Based on figures from the National Science Foundation, Santiago-Negron (1989) showed that Hispanics still accounted for only 2.8% of the Ph.D. degrees in psychology awarded in 1984. To make matters even worse, there is some indication that minorities may be losing ground. A disturbing trend in recent years suggests that the numbers of minority Ph.D.

degrees awarded in all fields seems to be decreasing rather than increasing. Based on figures derived from a 1984 Office of Civil Rights report, Santiago-Negron (1989) stated that "overall minority enrollment in graduate and professional schools appears to have peaked out in about 1976-77"(p. 8). In 1975-76, minorities had come to account for 7.9% of all doctorates awarded in the United States; by 1983-84, they accounted for only 5.5% of the total number of doctorates awarded (Adams, 1986; Clewell, 1987).

The Minority Graduate Faculty

Studies that have examined the numbers of minority faculty are in some ways more disturbing that those examining the effect of Affirmative Action programs on graduate school admission and completion. The two issues appear to be significantly interrelated. It has been proposed that without a critical mass of graduate faculty, minority students are prone, if not doomed, to feel isolated, alienated, and estranged and are therefore more likely not to complete their degree program (Olmedo, 1989). The most disturbing trend in these studies is the stability of the low numbers. In 1970 it was estimated that Blacks accounted for only 2.01 % of faculty positions in psychology and Hispanics accounted for only 0.48% (Boxley & Wagner, 1971). Padilla et al. (1973) surveyed the faculty in departments of clinical psychology and obtained statistics very similar to those obtained by Boxley and Wagner, that is, 2.02% for Blacks and 0.19% for Hispanics. Padilla et

al. (1973) concluded that there had been no significant change during the period from 1970 to 1972 in the number of minority faculty member positions in the clinical psychology programs across the United States.

Kennedy and Wagner (1979), in a follow-up to the studies of Boxley and Wagner (1971) and Padilla et al. (1973) found little change from 1971 and 1973 statistics in comparison to their 1977 estimates. Kennedy and Wagner (1979) found that Blacks still accounted for only 4.2% and Hispanics only 0.90% of graduate faculty positions in clinical psychology in 1977. Kennedy and Wagner also concluded that these minority faculty positions tended to cluster in certain areas of psychology, specifically in applied areas. They also discovered that minority faculty members were less likely to have attained tenure.

Other researchers had also noticed the severe minority underrepresentation on the graduate faculties in psychology, and had come to conclusions similar to those later reached by Kennedy and Wagner (1979). In 1977, 95% of the graduate faculty positions in clinical psychology were still held by non-minority persons (Suber, 1977). The consistency of the findings of these independent researchers states the case very strongly, especially since it is now thought that they were actually seeing the peak of the trend toward increasing minority faculty positions in psychology. In graduate departments of psychology in 1981, Whites still accounted for 93.8% of graduate faculty positions, with Hispanics

accounting for only 0.8% of the graduate positions (Russo, Olmedo, Stapp, & Fulcher, 1981).

Underrepresentation of Hispanics in academia is especially notable in light of their proportion of the total population in the United States. No substantial change in minority representation on graduate faculties has been registered in more recent years. Menges & Exum (1983), discovered that 92% of all full professors and 93.4% of associate professors were Caucasian. Olmedo (1989) has shown more recently that Whites still hold 92.3% and Hispanics only 1.1% of the graduate faculty positions in psychology. Professional schools of psychology have fared little better than the more traditional academic schools or departments of psychology in terms of minority faculty recruitment. Although professional schools of psychology seem to be more aggressive in recruiting and retaining minority faculty, the underrepresentation of minority students in these schools remains a serious problem. The underrepresentation of minorities in academia has a peculiar irony as most graduate schools tend to be located in metropolitan areas where minority groups are found in the highest concentration. In a recent survey by Bernal and Padilla (1982), 68% of the schools surveyed affirmed that in the community surrounding the graduate school the local ethnic population was 10% or greater. In fact, Blacks and Hispanics were identified most commonly as the largest identifiable ethnic group in the areas surrounding the

graduate schools surveyed. The most ironic aspect of underrepresentation is that many, if not most of these graduate schools are nestled in hotbeds of ethnic and cultural diversity. The possibility exists that the elitism of which psychology has often been accused may indeed have some basis in fact, and may reflect the general social class bias (Casas, Ponterotto, & Guitierez, 1986).

Underrepresentation and Underutilization

The underrepresentation of Hispanics is not only present in graduate schools of psychology but in all the professions. Hispanics were estimated to represent less than 0.1% of the total professional labor force (Stang, 1977). As noted above, Hispanics accounted for only 2.4% of the Ph.D. degrees awarded in psychology in 1979 (Grant & Eiden, 1982). Thus, the schools have a small pool from which to hire qualified Hispanic applicants for faculty positions. To compound the problem, there is some indication that even if successfully recruited the minority faculty are less likely to be tenured and more likely to receive less pay than their Caucasian colleagues (Suinn & Witt, 1982; Russo et al., 1981; Kennedy & Wagner, 1979).

The issue of tenure for minority faculty is a complicated one. It seems that in some ways minority faculty, because they are recruited on the basis of their minority status, are thereby set up to fail. Suinn and Witt (1982) surveyed graduate departments about recruitment and retention of minority faculty and concluded that one of the main reasons

for the failure of many minority faculty to gain tenure is because of too great an emphasis on minority service and not enough on research activities. They are hired with the expectation that they will be involved with time-consuming minority affairs but are still expected to produce research at the same level as their non-minority peers. It is easy then to understand why minorities are less likely to become tenured and more likely to gain employment elsewhere at a higher salary or where there is a higher concentration of minority persons (Suinn & Witt, 1982). The minority faculty are really set up to fail when their schedules are filled with minority service responsibilities in addition to their other regular duties as faculty. According to Olmedo (1989), the reason the minorities were hired is the reason they will be fired.

It is not very socially desirable for the psychological profession to admit to discrimination or apathy, if not outright exclusion of minorities from participation in all aspects of psychology, toward minority group concerns. However, institutional barriers that preclude recruitment and retention of minority faculty inhibit a greater theoretical understanding of minority needs in psychology (Suinn & Witt, 1982).

Several hypotheses have been offered as to why minorities are underrepresented in psychology. By far the most common and damaging is known as the "Deficit Hypothesis." According to some researchers (Hayes & Banks, 1972), this is

the conceptual framework unwittingly employed by the vast majority of professional counselors. The Deficit Hypothesis suggests that minorities have underlying deficiencies, either genetic or environmental, that limit their probability of achieving successful academic and/or social adjustment (Hayes & Banks, 1972).

This hypothesis is the most damaging because it is so widespread and because it implies that the answer to the problem of underrepresentation is not one that the field of psychology is responsible to change. If on one hand the problem is genetic, there is nothing for which psychology can be held responsible and nothing psychology can do to change the situation. On the other hand, if the deficiency is environmental, the solution is entirely sociological and societal changes must take place. Either way, the Deficit Hypothesis absolves psychology and its professional members from guilt and with it the responsibility for changing the current underrepresentation of minorities among both students and faculty.

Thus the problem of underrepresentation is a self-perpetuating one. Few minority students are admitted, therefore there are few who graduate. Because few graduate there are few minority faculty, and because there are few minority faculty few minority students will apply as there is not the critical mass of minority faculty necessary to maintain a quality environment that involves and appreciates a minority student's cultural differences and unique

identity struggle. A supportive environment is thought by some researchers to be a critical factor in student and faculty recruitment and retention (Olmedo, 1989; Persico, 1989). If psychology is to be serious about underutilization of mental health services by minorities, then it will have to move beyond the token involvement of minorities as students and faculty in the graduate programs in the United States. Without greater numbers of minority students and faculty in psychology little headway can be made in understanding and meeting the mental health needs of the minority population.

Summary of Main Factor III

Hispanics were found to be significantly underrepresented among students and faculty in graduate schools of psychology, and this underrepresentation is suggested as a cause of Hispanic underutilization. The underrepresentation of Hispanics in psychology appears to be a major factor in their underutilization of services.

Underrepresentation is a crucial issue not because of a strong preference of Hispanics for a Hispanic therapist, but because the language, culture, and social class differences appear to have a strong impact on underutilization. As long as Hispanics are underrepresented in psychology, as a profession and academic discipline, there appears to be little hope for understanding or providing for their mental health needs. Hispanic psychologists are desperately needed for service provision, as well as for developing linguistic

and ethnically sensitive methods of assessment and treatment of Hispanics.

It appears that the critical step in increasing utilization of mental health services by Hispanics is to involve more of the minorities in all aspects of psychology, in order to provide the impetus and energy needed to examine the relevant issues. Minorities can help recognize the distortion and biases inherent in many of the current paradigms of psychology (Clark, 1987). Minority psychologists could also begin to bridge the gaps in the research between theory and reality as well as provide necessary mental health services.

Conclusion

The problem of underutilization of mental health services by Hispanics despite their rapidly growing numbers was identified and estimates of the current Hispanic population in this country were cited. Hispanics are the second largest minority group in the United States, the largest minority group in the southwest, and the fastest growing minority group. Hispanics tend to immigrate to large metropolitan cities and in some of the largest cities of the United States they are already the largest minority group, or will soon become the largest.

Despite the large and growing population of Hispanics in the United States they do not utilize mental health services as much as would be expected given their numbers. Why?

This is the question that I have attempted to answer and clarify through this review of the literature. Why Hispanics underutilize mental health services is not an easy question to answer and a number of factors are involved in it. The present study identified three major factors: (a) psychotherapist bias, (b) cultural variables, and (c) underrepresentation of Hispanics in the field of psychology.

In conclusion, evidence of psychotherapist bias was found for social class and linguistic type biases but little evidence of ethnic bias. A number of cultural variables were also found to play a part in Hispanic underutilization: (a) Hispanic attitudes, (b) levels of acculturation, (c) alternative support networks, and (d) ethnic similarity and credibility. Finally, the underrepresentation of Hispanics among minority graduate students and faculty in psychology was found to play a crucial role in the current underutilization of mental health services by Hispanics. In the following concluding remarks, research implications are considered together with recommendations for future study of the three main factors emphasized in this review.

Research Implications

The most striking finding in this review of the literature on the utilization of mental health services by Hispanics, is the lack of well-controlled studies. In some sense, the relative lack of research points out very strongly the lack of interest in the topic. From the 1990 Census data, the Hispanic population in the United States is

expected to have grown significantly. For that reason, a more concerted effort is needed to examine carefully the significant issues involved in the delivery of effective, culturally sensitive mental health services to Hispanics. Particular areas need research attention, for example, more analog studies designed to measure possible ethnic biases. It is still unclear from the current research whether Hispanics are treated differently due to their ethnicity. It is also unclear whether there exists a minimizing bias or an overpathologizing bias, or both.

One of the most indicting criticisms of the past research is the use of non-professional counselors and college students as subjects. Future research ought to employ psychologists of a varying skill levels as subjects and to vary the client ethnicity in analog studies. To further assure external validity, in analog studies where the psychologist's ethnicity is varied, researchers should consider using subjects who vary in their level of acculturation. Perhaps with better-controlled studies a pattern of ethnic bias would emerge more clearly.

From the literature reviewed it is clear that social class and linguistic biases exist toward Hispanics but the research needs to move beyond merely establishing existence of bias. Research focused on how biases are established, influenced, and changed would likely be more productive. The present review has established that psychologists have biases against low-income patients and non-English speaking

patients. However, the question remains to what effect, if any, these biases have on the quality of treatment of the Hispanic patient.

The development of accurate psychological assessment methods and procedure is another area that needs research attention critically. Standardization of Spanish versions of intellectual and personality assessment instruments is urgently needed. Accurate assessment and diagnosis is a critical step in starting to meet the mental health needs of Hispanics. Beyond assessment and diagnosis, understanding the most effective treatment methods for Hispanic clients is still relatively unstudied. How does the client's level of acculturation and language skills affect treatment outcomes? These are research questions that are as yet unanswered. With so much to be done and with such important gaps in the research, how can these questions be answered? They cannot even begin to be answered without greater involvement of Hispanics in graduate training in psychology.

Far too much time and energy seems to have been spent in trying to discover if the client and therapist ethnicity match, or mismatch, makes a difference. Trying to see if ethnic matching makes a difference is a mute point if the client and therapist do not speak the same language. At present there is a serious shortage of Hispanic therapists. With the Hispanic population growing as it is, its demand for service will likely increase (Sue, 1988). Having a common language is essential to effective delivery of mental

health services to Hispanics. Therefore, psychology's commitment to recruitment of Hispanics ought to be a moral and ethical one, based on the American Psychological Association's own standards and mission.

The stable underrepresentation of Hispanics among graduate school students and faculty in psychology reflects apathy and lack of effort on the part of many universities. If psychology intends to become serious about the problem of underutilization of mental health services by Hispanics, the first step is to increase the number of Hispanic students and faculty. Without the critical mass of interested professionals the problem of Hispanic underutilization of mental health services will never be fully understood.

Research Recommendations

There are so many gaps in the research with Hispanics that it is difficult to make specific recommendations. However, what appears to be needed is a rigorous, systematic research program focused less on establishing whether or not bias exists and more on the impact bias has on the assessment, diagnosis, and treatment of Hispanic clients.

Assessment techniques that are less language-bound appear to show some promise. Personality assessment using the projective Rorschach Inkblot Test appears to have great potential but norms on diverse Hispanic populations are needed. A culturally sensitive, Spanish-language(MMPI-style) paper-and-pencil personality inventory needs to be developed and normed on a representative Hispanic population.

Specific treatment approaches with Hispanic populations need to be studied as it is not clear which approaches and techniques best fit the Hispanic patient. Interaction effects are likely to be important as Hispanics are a very diverse group and may also come from different socioeconomic backgrounds.

A more international approach is needed. Hispanics who are living in the United States are a select group, when compared to Hispanics from other regions of the world, as they may have come to the United States to escape political persecution (e.g., Cubans) or economic problems (e.g., Mexicans) or for various other reasons. An important question that begs an answer is how Hispanics in the United States compare to Spanish-speaking people from other parts of the world.

Finally, research is urgently needed to understand the underrepresentation of Hispanic graduate students and faculty. It is not known why so few Hispanics enter the field of psychology. What is involved in the career decisions made by Hispanic college and high school students and why is it they are not choosing psychology as a viable career option? The answer to this question is fundamental to our understanding of underrepresentation. If more Hispanics are not involved in the discipline who else has the language skills, interest, or insight to launch research in search of answers to the pressing research questions focused on in this review?

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